MANATEE CARDIOVASCULAR WELLNESS INSTITUTE

For Office Use Only:

Patient Number: _____

OFFICE AND FINANCIAL POLICY & AGREEMENT

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Scheduling and registration: We require you to provide your medical insurance card(s), photo identification, address, date of birth, social security number and phone number. If you receive health benefits through a spouse we require you to provide their address, date of birth, and phone number.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and may ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office of any changes.

Keeping Appointments for Consultation, Follow up or Testing: All appointments are very important to initiate and/or execute my treatment plan. During these appointments, my physician might order tests, review my plan of care, prescribe medication, or even discover and treat a serious health condition. If I don't show up for my appointment, or miss my appointment and fail to reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. (_____) Initial

In addition, I understand that missing or not showing up for my appointment creates a significant hardship for my physician and is not fair for other patients who would like to access cardiology services by my physician's practice. I will make every effort to notify my physician, his or her nurse or the scheduling team a minimal of 48 hours in advance of my appointment cancellation and reschedule missed appointments, as soon as possible. (_____) Initial

If you are unable to make your appointment due to a *bona fide* emergency no cancellation fee will apply provided you supply written documentation or proof of the emergency. In all other instances:

- A **"$25.00 no show cancellation fee"** will be charged, without exception, for un-kept office visit appointments not canceled 48 hours before the scheduled appointment time. (_____) Initial
- A **"$50.00 no show cancellation fee"** will be charged, without exception, for un-kept ultrasound appointments not canceled 48 hours before the scheduled appointment time. (_____) Initial
- A **"$100.00 no show cancellation fee"** will be charged, without exception, for un-kept nuclear stress testing appointments not canceled 48 hours before the scheduled appointment time. This test requires a daily purchase and delivery of pharmaceuticals with a shelf life of only one day. (_____) Initial

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage and to contact your carrier prior to receiving services to verify your coverage and responsibilities.

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Authorizations: You are responsible to make sure all necessary referrals, pre-certifications or other required documentation are obtained prior to your appointment. If our team determines that your plan requires an authorization, and you do not provide such referral, authorization or certification, you may be required to sign a waiver in order to receive services or the appointment may be rescheduled.

Copayments: It is **our responsibility**, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is **your responsibility**, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. There will be a Service Charge on all returned checks.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and notice, your account may be sent to a collection agency.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. Payment arrangements may be made on a case by case basis by contacting us and providing proof of financial hardship.

Medical Records: A fee of $1.00 per page for the first 25 pages and .25 for each additional page will be charged for a copy of your medical records for the purpose of transferring care or personal use. There is no charge for medical records that we are requested to forward by mail or fax to other treating physicians.

Form Completion: A fee of $20 will be charged for the completion of most forms (disability, FMLA, etc.)

Prescription Refills: Please call your pharmacy and ask them to send us an electronic request for a refill of your prescription(s). Upon receipt, please allow us up to 48 hours for the request to be completed.

Patient Acknowledgment

I have read and understand the above agreement and agree to abide by the policies outlines above.

Signature: _____ Date: _____